Bloomfield Hills Schools

See Reverse Side for Instructions on Completion of this Form

ATTENDING PHYSICIAN STATEMENT

(Must be completed by doctor)

Employee Name: _____

Physician Name: _____

Field of Specialization: _____

Diagnosis: _____

I last examined or treated the employee for this condition on: _____

Please select one of the following options:

In my opinion the employee may return to work without restrictions on: _____

OR

In my opinion the employee may return to work with the (specific restrictions) listed below on:

_____

The employee has the following specific work restrictions (indicate all restrictions on the employee's work activities), including but not limited to, hours of work, specific job duties the employee may perform on a limited basis as well as duties the employee may not perform at all:

_____

OR

In my opinion the employee may not return to work at this time.

I will next examine the employee on: _____

The employee remains disabled through: _____

_____ _____

Date Physician Signature

Return form to:
Bloomfield Hills Schools • Attn: Benefits • 7273 Wing Lake Road • Bloomfield Hills, MI 48301
(P) (248)-341-5431 ~ A faxed copy of this document is prohibited~

Revised 09/14

INSTRUCTIONS

USE OF FORM: This form is considered a multi-purpose tool of reporting updated medical information multiple times throughout the staff member's period of incapacity from work as well as for any staff member working with Physician ordered work restrictions. All areas of the form must be fully completed or it will not be accepted. This includes the date of the next visit. A faxed copy is prohibited due to issues with fraud. The original document must be presented to the Benefits Coordinator on the due date indicated on the FMLA notice form. Failure to submit timely updates on the due date may result in a suspension of sick and/or disability pay until the first pay period following such time the staff member submits full and properly completed medical documentation using this form. Hand written notes from Physician and or typed notes from Physician are not accepted by Bloomfield Hills School District. The responsibility for submitting the Physician Statement and the Department of Labor FMLA forms is solely that of the Staff Member.

YOUR INFORMATION: Your medical information is protected by the Health Insurance Portability and Accountability Act (HIPPA). Only authorized employees will have access to your protected health information (PHI). The only information shared with your Supervisor is period of incapacity from work and date of release to return to work with or restrictions.

Should you have questions concerning this form or FMLA please contact the Benefits Coordinator at sdare@bloomfield.org or at (248) 341-5431.